ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROVIDER REGISTRATION FORM

SHADED FIELDS FOR AHCCCS PROVIDER REGISTRATION STAFF ONLY *Please Type or Print in Ink*

SECTION I

1a) PROVIDER AHCCCS ID NUMBER (Complete Only if you are currently registered and have a Provider No)	1b) PROVIDER NPI (NATIONAL PROVIDER IDENTIFIER) NUMBER (if applicable)
2) PROVIDER NAME(Last Name/First Name/Middle Initial or business/facility name)	
3) SOCIAL SECURITY NUMBER	4) DEGREE / 5) ENROLLMENT BEGIN DATE
6) PROVIDER TYPE	7) FFS TYPE / 8) IHS INDICATOR
9) APPLICATION DATE Month ____ Day ____ Year ____	10) FIRST DATE OF SERVICE FOR WHICH A CLAIM WILL BE SUBMITTED Month ____ Day ____ Year ____

SECTION II ADDRESS INFORMATION

CORRESPONDENCE ADDRESS

ADDR C SITE 01

11) STREET LINE 1: _____

12) STREET LINE 2: _____

13) CITY/STATE/ZIP: _____

14) COUNTY CODE: _____ 15) COUNTRY CODE: _____

16) BUSINESS PHONE: (___) ___ ____ 17) EMERGENCY PHONE (___) ___ ____

18) ATTENTION TO: _____

PAY-TO ADDRESS

ADDR P SITE 01

11) STREET LINE 1: _____

12) STREET LINE 2: _____

13) CITY/STATE/ZIP: _____

14) COUNTY CODE: _____ 15) COUNTRY CODE: _____

16) BUSINESS PHONE: (___) ___ ____ 17) EMERGENCY PHONE (___) ___ ____

18) ATTENTION TO: _____

ADDITIONAL PAY-TO INFORMATION 20) END DATE: _____ 21) EMPLOYER TAX ID: _____

SERVICE ADDRESS

ADDR S SITE 01

11) STREET LINE 1: _____

12) STREET LINE 2: _____

13) CITY/STATE/ZIP: _____

14) COUNTY CODE: _____ 15) COUNTRY CODE: _____

16) BUSINESS PHONE: (___) ___ ____ 17) EMERGENCY PHONE (___) ___ ____

18) ATTENTION TO: _____

19) BEGIN DATE: _____ 20) END DATE: _____

ADDITIONAL SERVICE INFORMATION: 22) PAY-TO LOCATION CODE: _____

Reset Form

PAY-TO ADDRESS

ADDR SITE
P 02

11) STREET LINE 1: _____

12) STREET LINE 2: _____

13) CITY/STATE/ZIP: _____

14) COUNTY CODE: _____ 15) COUNTRY CODE: _____

16) BUSINESS PHONE: (___) ___ ____ 17) EMERGENCY PHONE (___) ___ ____

18) ATTENTION TO: _____

ADDITIONAL PAY-TO INFORMATION 20) END DATE: _____ 21) EMPLOYER TAX ID: _____

SERVICE ADDRESS

ADDR SITE
S 02

11) STREET LINE 1: _____

12) STREET LINE 2: _____

13) CITY/STATE/ZIP: _____

14) COUNTY CODE: _____ 15) COUNTRY CODE: _____

16) BUSINESS PHONE: (___) ___ ____ 17) EMERGENCY PHONE (___) ___ ____

18) ATTENTION TO: _____

19) BEGIN DATE: _____ 20) END DATE: _____

ADDITIONAL SERVICE INFORMATION: 22) PAY-TO LOCATION CODE: _____

PAY-TO ADDRESS

ADDR SITE
P 03

11) STREET LINE 1: _____

12) STREET LINE 2: _____

13) CITY/STATE/ZIP: _____

14) COUNTY CODE: _____ 15) COUNTRY CODE: _____

16) BUSINESS PHONE: (___) ___ ____ 17) EMERGENCY PHONE (___) ___ ____

18) ATTENTION TO: _____

ADDITIONAL PAY-TO INFORMATION 20) END DATE: _____ 21) EMPLOYER TAX ID: _____

SERVICE ADDRESS

ADDR SITE
S 03

11) STREET LINE 1: _____

12) STREET LINE 2: _____

13) CITY/STATE/ZIP: _____

14) COUNTY CODE: _____ 15) COUNTRY CODE: _____

16) BUSINESS PHONE: (___) ___ ____ 17) EMERGENCY PHONE (___) ___ ____

18) ATTENTION TO: _____

19) BEGIN DATE: _____ 20) END DATE: _____

ADDITIONAL SERVICE INFORMATION: 22) PAY-TO LOCATION CODE: _____

Reset Form

SECTION III

LICENSING*

23) LICENSE NUMBER	24) ISSUE DATE (MM/DD/YYYY)	25) EXPIRATION DATE	26) NEXT RENEWAL DATE

* A COPY OF THE LICENSE MUST BE ATTACHED

PROVIDER SPECIALTY INFORMATION- MANDATORY FOR PHYSICIAN, DENTISTS, PODIATRISTS, OSTEOPATHS, AND REGISTERED NURSE PRACTITIONERS

27) SPECIALTY	28) BEGIN DATE (MM/DD/YYYY)	29) END DATE

BED COUNT INFORMATION - HOSPITALS, NURSING HOMES, AND HOSPICES ONLY

30) BED TYPE	31) STATE CERTIFIED COUNT	32) MEDICARE CERTIFIED COUNT	33) MEDICAID CERTIFIED COUNT	34) BEGIN DATE (MM/DD/YYYY)	35) END DATE

SECTION IV

AUTHORIZED SIGNATURE

36) SIGNATURE	37) PRINT NAME	38) BEGIN DATE (MM/DD/YYYY)

Reset Form

GROUP BILLING AUTHORIZATION

39) GROUP NAME/AHCCCS ID NUMBER AND/OR NPI NUMBER	40) ASSOCIATION BEGIN DATE (MM/DD/YYYY)	41) ASSOCIATION END DATE

MEDICARE INFORMATION **(Mandatory for all providers. If not a Medicare provider indicate by placing N/A in block #42)**

42) MEDICARE ID NO	43) MEDICARE COVERAGE	44) INTERMEDIARY NUMERIC CODE	45) CARRIER NUMERIC CODE	46) BEGIN DATE (MM/DD/YYYY)	47) END DATE

Has the practice/organization that you represent or any of the signatories listed in (36) ever applied for or received an AHCCCS provider identification number under any other name than noted on this form?

☐ NO

☐ YES (Please explain)

Has the practice/organization that you represent or any of the signatories listed in (36) ever been terminated, suspended, advised of any deficiencies or otherwise subject to any corrective or disciplinary action by a governmental body?

☐ NO

☐ YES (Please explain)

I hereby authorize the groups listed in (39) to bill on my behalf and receive payment for services provided to AHCCCS members.
I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.

48) _____
PROVIDER SIGNATURE (ONLY)

49) _____
DATE

50) _____
PROVIDER NAME (PLEASE TYPE OR PRINT)

Reset Form